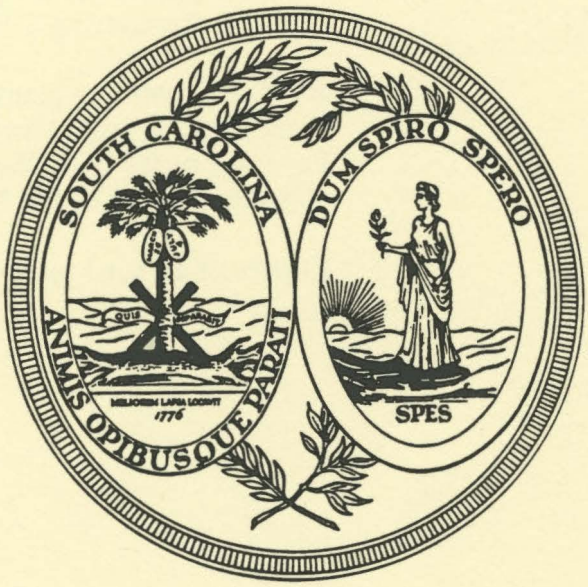
South Carolina Legislative Audit Council

LAC

Report to the General Assembly

May 1990

A Limited-Scope Review of the South Carolina Continuum of Care for Emotionally Disturbed Children



LAC/CC-89-1

Legislative Audit Council

400 Gervais Street
Columbia, SC 29201
(803)253-7612

Authorized by §2-15-10 *et seq.* of the South Carolina Code of Laws, the Legislative Audit Council, created in 1975, reviews the operations of state agencies, investigates fiscal matters as required, and provides information to assist the General Assembly. Some audits are conducted at the request of legislators who have questions about potential problems in state agencies or programs; other audits are performed as a result of statutory mandate.

The Legislative Audit Council is composed of three public members, one of whom must be a practicing certified or licensed public accountant, and six ex officio members.

Audits of the Legislative Audit Council conform to generally accepted government audit standards as set forth by the U.S. General Accounting Office.

All documents are produced using IBM-compatible personal computers, WordPerfect 5.0 software and a Hewlett-Packard LaserJet series II printer. Most graphs and figures are generated using Lotus Freelance Plus 3.0 software.

Copies of all LAC audits are available at no charge.

A Limited-Scope Review of the South Carolina Continuum of Care for Emotionally Disturbed Children was conducted by the following audit team.

Audit Manager
Cheryl A. Ridings
Assistant Director

Audit Team
Jane I. Thesing
Senior Auditor
Lyndon P. Chappell, CPA
Senior Financial Auditor

Typography
Candice H. Pou
Maribeth Rollings Werts

LAC

Report to the General Assembly

A Limited-Scope Review of the South Carolina Continuum of Care for Emotionally Disturbed Children

Contents

Executive Summary

The South Carolina Continuum of Care for Emotionally Disturbed Children is an agency created originally as a pilot project to develop and coordinate services for a specific population, severely emotionally disturbed children who have not been adequately served by the existing service delivery system.

Our limited-scope review of the Continuum's operations was completed in a context which makes evaluation difficult. Factors which limited our ability to evaluate the Continuum included:

- Lack of longitudinal data sufficient for evaluative conclusions--the agency was created in 1986.
- Difficulty in identifying similar programs--programs to improve services to this population developed nationally in the 1980's and have no standard governmental organization.
- Legislative changes--in 1989, the General Assembly changed the composition of the Continuum's governing body and the agency responsible for the Continuum's administrative support.

Overall, given these limits, we found few problems with the Continuum's performance in the areas reviewed, and we identified progress that has been made in the development and delivery of services to the target population. The agency and its programs are still evolving. We observed that the Continuum's staff has demonstrated an ongoing commitment to developing policies and procedures, evaluating results, and making improvements based on those results.

In response to the audit request, the objectives of the review of the Continuum were formulated as questions, and the answers are presented in narrative form rather than as traditional audit findings. The objectives and the results of our review are summarized as follows:

1 *Has the Continuum of Care offered services appropriate to legislative intent and national criteria?*

Evidence indicates that the Continuum of Care has offered services in line with statutory requirements and national criteria. Some service goals, specifically those of offering community-based services in the least restrictive environment, have not yet been met. However, the Continuum's process for service development offers assurance that continued progress toward these goals is planned (see p. 7).

2 *Does the Continuum of Care's client selection policy include adequate controls to ensure that clients are selected in accordance with legislative intent, and with a minimum of delay and expense?*

We reviewed the Continuum's client selection process and determined that it has adequate controls to ensure that those children who are severely emotionally disturbed and have exhausted available services are selected to receive Continuum services. However, delays and expense are effects of the process. Also, the Continuum has not promulgated regulations for its eligibility criteria, as required by the Administrative Procedures Act (see p. 13).

3 *What has been the Continuum of Care's average cost per client served, and is this reasonable?*

We found the average cost per Continuum client to be approximately $18,319, $20,298, and $23,045 in FY 86-87, FY 87-88, and FY 88-89, respectively. Based on costs of the most directly comparable program identified, the Continuum's costs are not unreasonable (see p. 19).

4 *How does the Continuum of Care measure client progress, and are management controls adequate to ensure that clients receive effective service?*

The Continuum has measured client progress by annual client outcome surveys, and the results of these surveys have shown a favorable trend. The surveys are informal and the

results are unverified, but they can be a useful management tool.

The Continuum has adequate management controls to ensure the quality of the case management services it provides and of services procured for clients by program contracts. However, improvement is needed in the controls to ensure the quality of services procured by individual contracts (see p. 23).

5 *How many Continuum clients have been placed in out-of-state treatment programs, and why?*

From July 1, 1986 to June 30, 1989, thirty Continuum of Care clients received treatment in residential placements located outside of South Carolina. Twenty-three of these remained out-of-state on June 30, 1989. A shortage of long-term residential nonhospital facilities, and the lack of an adequate sex-offender treatment program in South Carolina have been cited as the reasons for many of these placements (see p. 28).

In addition to responding to the review's objectives, we also identified the agency's automated information system and source of funding as areas not directly related to the audit's scope where further study is needed (see p. 31).

Introduction and Background

Audit Objectives

The Audit Council was requested by a member of the General Assembly to conduct a limited-scope review of the South Carolina Continuum of Care for Emotionally Disturbed Children. The review focused on five specific aspects of the Continuum's operations, and the objectives were stated as the following questions:

1 Has the Continuum of Care offered services appropriate to legislative intent and national criteria?

2 Does the Continuum of Care's client selection policy include adequate controls to ensure that clients are selected in accordance with legislative intent, and with a minimum of delay and expense?

3 What has been the Continuum of Care's average cost per client served, and is this reasonable?

4 How does the Continuum of Care measure client progress, and are management controls adequate to ensure that clients receive effective service?

5 How many Continuum clients have been placed in out-of-state treatment programs, and why?

In line with the objectives, which asked for information as well as evaluation, the report does not present traditional audit findings, but rather answers the questions in narrative format.

Scope and Methodology

The review of the Continuum of Care was limited to the scope imposed by the objectives and, as a result, excluded many facets of agency operations, such as accounting, personnel, and procurement. We did not evaluate the administrative support received from the Department of Mental Health and the Health and Human Services Finance Commission. We obtained and

reviewed information and documents from the Continuum's state office in Columbia and the regional offices.

The general period of review was FY 86-87 through FY 88-89. FY 86-87 was excluded for some areas, due primarily to difficulty in obtaining information. In some cases, we extended the scope to early 1990 in order to more fully respond to the objectives of the review.

Evidence was drawn primarily from the Continuum's records, including financial records, client records, manuals, working papers and reports. We also conducted a survey of case service coordinators. We interviewed Continuum staff and employees of other South Carolina agencies, agencies in other states and a federal agency. Extensive sampling was not necessary to fulfill the audit objectives, although some limited nonstatistical sampling was performed.

We verified the Continuum's financial records by reconciling them with those of the Comptroller General. Some data from the agency's client information system was compared with client files and with agency contract records. However, since the verification of this information was not central to the audit objectives, the report contains unverified data from the Continuum's client information system, contract records, and surveys. We also reported unverified information obtained from other agencies.

Because the Continuum of Care is in many ways a unique agency, responsible for coordinating a varied system of services to a specific population, criteria from other agencies and programs was difficult to obtain. Most useful for comparison was information obtained from the North Carolina Willie M. program and the research study *A System of Care for Severely Emotionally Disturbed Children & Youth* (Stroul and Friedman, 1986), published by the federal Child and Adolescent Service System Project (CASSP).

We evaluated the internal controls of the Continuum's automated client information system and found them to be generally weak (see p. 31). However, the system's reliability was sufficient for the audit's objectives, and the cost of manual

extraction of data would have been prohibitive. We evaluated internal management controls over the client selection process (see p. 13) and the quality of service received by clients (see p. 23).

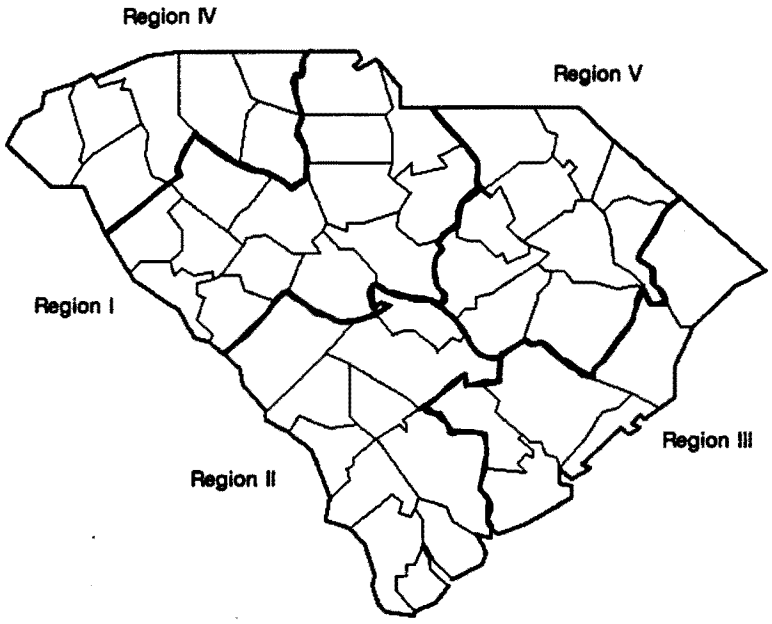
The audit was conducted in accordance with generally accepted government auditing standards.

Background and History

The South Carolina Continuum of Care for Emotionally Disturbed Children was established through a proviso to the 1983 Appropriation Act as a three-year pilot project in the midlands. The project was to establish and demonstrate a "continuum of care" service delivery approach for severely emotionally disturbed children who had "fallen through the cracks" of the existing service delivery system. Forty clients age 11 to 14 were served by the pilot project in Richland, Lexington, Kershaw, and Fairfield counties.

In 1986, the General Assembly permanently established the Continuum of Care and provided for a ten-member governing policy council which included legislators and heads of other interested state agencies, including the Departments of Mental Health (DMH), Social Services (DSS), Youth Services (DYS), Education (SDE), and Mental Retardation (DMR). Administrative support for the Continuum's personnel, procurement and accounting functions was furnished by DMH. The Continuum's mission was expanded to the delivery of services on a statewide regional basis, and five regions covering the state were established (see map on p. 4).

Map: South Carolina Continuum of Care Regions



Source: Continuum of Care.

In 1989, the Continuum's legislation was amended and its governing body changed to a lay board. One member is appointed by the Governor from each of the agency's five regions. An advisory council of representatives of other agencies and interested parties was created. Also, the 1989 amendments changed the agency responsible for the Continuum's administrative support from DMH to the Health and Human Services Finance Commission.

The Continuum has a state office in Columbia and offices in the five regions. As of March 1, 1990, the Continuum had 78 state FTEs under an executive director (see Appendix B).

Summary of Revenues and Expenditures

	FY 86-87	FY 87-88	FY 88-89
Revenues			
General Fund	$1,164,123	$1,790,684	$2,349,481
Patient Pay	400,000	400,000	400,000
EIA Funds[a]	3,000,000	4,000,000	4,000,000
Carryforward	•	273,159	310,810
Total	**$4,564,123**	**$6,463,843**	**$7,060,291**
Expenditures			
Personal Services	$1,249,534	$1,432,325	$1,584,459
Employer Contributions	229,915	287,885	322,075
Contractual Services	108,383	101,994	111,291
Supplies	59,221	29,918	36,375
Fixed Charges	178,299	211,418	217,970
Travel	74,010	70,961	91,007
Equipment	79,658	9,666	18,148
Case Services	1,480,880	2,356,467	3,719,034
Transportation	2,339	5,495	6,569
Total	**$3,462,239**	**$4,506,129**	**$6,106,928**
Excess of Revenues Over Expenditures	$1,101,884	$1,957,714	$953,363
Authorized Carryforward	273,159	310,810	596,191
Lapsed	828,725	1,646,904	357,172

[a]The Continuum, while authorized to receive these amounts, actually received $2,000,000 in FY 86-87 and $2,500,000 in FY 87-88. This explains the large unused appropriations in those years.
Source: Department of Mental Health--unaudited.

The Education Improvement Act (EIA) of 1984 provided for the Continuum to receive EIA funds through a contract with the Department of Education. The Continuum has received the majority of its funding from EIA funds each year since 1985. The agency has also been funded by general funds and patient pay funds collected by DMH (see table above). The Continuum has increased the number of slots available for clients as increased funding has become available. As of January 1990, there were 274 client slots distributed throughout the five regions. However, the Continuum's 1988-89 Annual Report estimated that at least 600 children in South Carolina are

eligible for services; as of June 30, 1989, there were 197 eligible applicants who could not be served (see p. 13).

As stated in §20-7-5640 of the South Carolina Code of Laws, the Continuum serves children "whose severity of emotional, mental, or behavioral disturbance requires a comprehensive and organized system of care." According to demographic information produced by the Continuum, as of June 30, 1989, a majority of the clients were male (71%), age 16 and older (61%), and in special education status (94%). Eighty-one percent had had out-of-home placements; 54% were living with parents at the time of acceptance. A high percentage of the clients were or had been assaultive (75%), and destructive of property (75%). Thirty-four percent had been adjudicated criminal and/or status offenders. Many (53%) had also been neglected or abused.

Has the Continuum of Care offered services appropriate to legislative intent and national criteria?

Evidence indicates that the Continuum of Care has offered services in line with statutory requirements and national criteria. Although some service goals have not yet been met, the Continuum's process for service development offers assurance that continued progress toward these goals is planned.

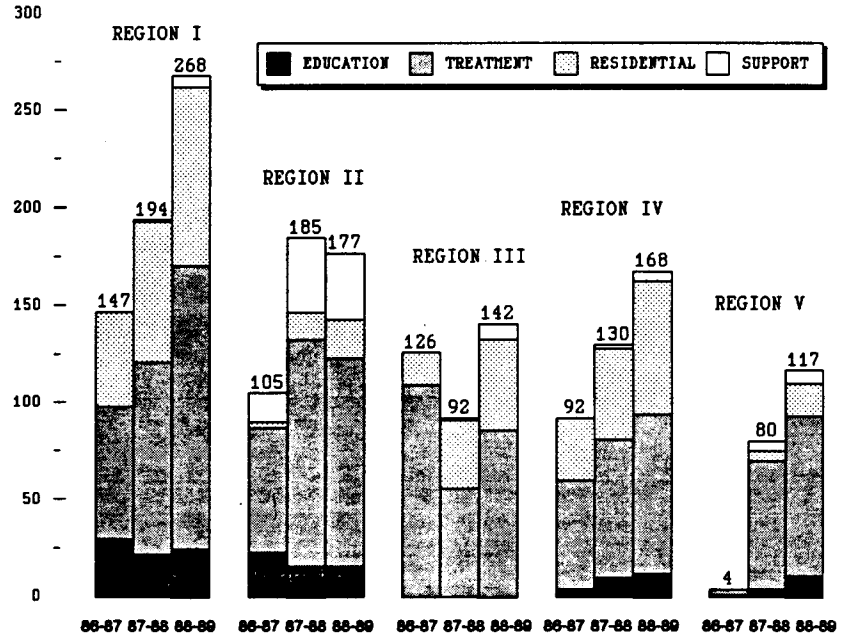
The purpose of the Continuum, as stated in §20-7-5610 of the South Carolina Code of Laws, is to "develop and enhance the delivery of services to severely emotionally disturbed children and youth." The law further defines the population to be served as those who have exhausted existing available treatment resources or services, and whose severity of disturbance requires a comprehensive and organized system of care. The Continuum is mandated to procure services needed by its clients and offer case management to coordinate and monitor the services.

A need for the services offered by the Continuum has been recognized elsewhere. As a result of a lawsuit on behalf of children who were seriously emotionally handicapped and assaultive, North Carolina established the Office of Willie M. Programs (Willie M.) in its Division of Mental Health, Mental Retardation and Substance Abuse Services of the Department of Human Resources to offer case management and similar services to this population. Nationally, the federal government has recognized the need to improve systems for service delivery for severely emotionally disturbed children and adolescents, and has funded grants to states and local governments through its Child and Adolescent Service System Program (CASSP).

We reviewed the services offered by the Continuum from FY 86-87 through FY 88-89. The Continuum offers case management for all of its clients. Because of the severity of the clients' needs, each service coordinator assumes responsibility for only 10-12 cases. The Continuum procures, in addition, a wide array of educational, residential and treatment services. The services in the Continuum's array comply with statutory requirements and are similar to those offered by the North Carolina Willie M. program.

The services needed by an individual client are determined by a planning team composed of the Continuum's case services coordinator, representatives from child-serving agencies such as the school district, DSS, or DMH, other service providers, the family/guardian, and the client. If the needed services are not available from an existing source, the service coordinator may procure the service by means of an individual contract. These services are termed "wrap around" services because they are tailored to the needs of the client. The Continuum initiated 774 contracts for individual services for the 265 total clients served in FY 88-89. If a group of clients need a similar service, the Continuum may develop a program contract to meet the need. There were 21 program contracts for FY 89-90. Graph 1.1 shows, by region, services purchased by the Continuum. Table 1.1 shows the Continuum's array of services.

Graph 1.1: Continuum of Care Purchased Services by Region[a]



[a]Numbers reflect number of Continuum-funded contracts for individual services, number of participants in program contracts. Does not include services paid for by other agencies or by the Continuum by means other than a contract.
Source: Appendix A.

Table 1.1: Continuum of Care Array of Services

Service
Educational
Regular Public Schools
Itinerate Educational Services
Resource Room
Self-Contained
Psycho-educational Services
Homebound Instruction
Tutoring
Treatment
Early Identification and Treatment
Psychological Evaluation
Medical/Psychiatric Evaluation
Counseling
Therapy
In-Home Family Intervention
Day Treatment
Community Crisis Stabilization
In-patient Crisis Stabilization
Short-term Non-Hospital Evaluation and Treatment (secure)
Short-term Psychiatric Hospital
Long-term Psychiatric Hospital
Activity Therapy
Positive Role Model
Behavior Management
Independent Living Skills
Vocational Services
Residential
Supervised Independent Living
Respite
Foster Care
Low/Moderate Management Therapeutic Foster Care
High Management Therapeutic Foster Care
Low/Moderate Management Therapeutic Group Home Care
High Management Therapeutic Group Home Care
Wilderness Camp
Long-Term Residential Treatment
Support
Transportation
Clothing
Medical
Legal
Other

Source: Continuum of Care.

The Continuum is required by law to augment existing resources rather than duplicate them. Our evidence indicates that the agency has complied with this requirement. In some areas, such as vocational services or education, where other agencies offer services, the Continuum has rarely provided services. Data furnished by the Continuum indicated that for the period March 1988 through June 1989, approximately 56% of the services received by Continuum clients were fully funded by the Continuum while approximately 36% were not funded by the Continuum, but by other public and private sources. The remaining 8% were partially funded by the Continuum.

Service Development

The Continuum has a process for developing needed services by means of an annual service development plan. The plan assesses clients' unmet needs for services, current service availability, other agencies' responsibilities for service provision, and the potential for service provision by the public and private sectors. The result of this planning process is a priority schedule for service development designed to increase the availability of services in all regions.

As a result of this process, the Continuum has contracted for the development of services which were not available previously in the state and has brought new vendors into the state. Services which have been developed through this process include in-home intervention, high management group care, high management therapeutic foster care, and secure nonhospital crisis management. Services developed as a result of Continuum action have also been used by other state agencies. For example, one provider that first came to South Carolina to fulfill a Continuum contract now has contracts to provide services for DSS, DYS, and DMH.

Least Restrictive, Community-based Services

It is difficult to evaluate the Continuum's progress toward the service goal of offering community-based services in the least restrictive setting that is clinically appropriate for its clients.

Section 20-7-5650 of the South Carolina Code of Laws states the Continuum is to develop its services on a statewide regional basis. The 1989 amendments to its legislation specify that the Continuum is to meet the needs of its population "to the extent possible within this State." The law also states that clients are to be served "in the least restrictive, most appropriate setting." Although these provisions were not a part of the Continuum's statute during the period under review, it has been the Continuum's formal policy since 1986 to offer services in the least restrictive setting.

The study, *A System of Care for Severely Emotionally Disturbed Children & Youth* (Stroul and Friedman, 1986), a work resulting from research done by the federal CASSP program and the Florida Mental Health Institute, suggests also that a model system of care should be community-based. Also, the model system should offer services within the least restrictive, most normative environment that is clinically appropriate.

The Continuum does not yet have a full array of services in each of the five regions. For example, only two of the regions have psychoeducation or day treatment programs. And only one region to date has a secure nonhospital short-term evaluation and treatment program. However, we found clients in all regions have access to most services in the array. For the years FY 86-87 through FY 88-89, the number of different services for which contracts were initiated for clients ranged from 18 in regions IV and V to 25 in region I. However, clients cannot always be served in their regions or their communities. They also cannot always be served in the state (see p. 28).

The Continuum has gradually expanded its service offerings as it has grown from a four-county pilot project in 1983. The agency's former governing board, the Policy Council, in 1988, determined the strategy of first enhancing the services in the midlands region to make the array complete in that area. As a result, this region offers the greatest number of services. Current Continuum policy, as stated in the 1989 service development plan, is for "a move toward equity among regions in terms of funding and availability of services." This is reflected in the priorities for service development stated in the plan. The

12 programs with the highest priority for development are distributed among the remaining 4 regions.

We reviewed the services offered by the Continuum and derived data on the portion of clients and Continuum dollars devoted to services which could be considered restrictive (or institutional, as opposed to home-like). For FY 87-88 and FY 88-89, the two years for which this data is available, the Continuum spent 22.5% and 26.3%, respectively, of its funds for purchased services for services such as hospitalization and long-term residential treatment, which are considered restrictive. Also, as of July 1, 1989, 77 of 234 (33%) Continuum clients were in placements which could be termed "institutional" (out-of-state, long-term residential treatment centers, psychiatric hospitals, DMR, DYS or other detention facility).

We compared the Continuum's expenditures for restrictive services with those of the Willie M. program in North Carolina. For the two years compared, Willie M. spent an average of 7% for services we defined as restrictive while the Continuum spent an average of 25%. Also, as of July 1989, the Willie M. program reported 147 of 1,070 (14%) of its clients in placements we defined as institutional.

However, these discrepancies could be, in some measure, attributable to differences in client populations. The Willie M. program serves the entire eligible population of severely emotionally disturbed children in the state (1,261 in FY 88-89). On the other hand, the Continuum serves only the most severely disturbed (265 in FY 88-89) of its potential eligible population, estimated to be at least 600 (see p. 5). Because the most severe cases would require more restrictive services, it could be expected that the Continuum would spend a larger percent for these services.

In conclusion, the available data is not adequate for evaluation of whether the Continuum has acted as required to offer the least restrictive treatment that is clinically appropriate. Continuing progress is needed in this regard, as well as in offering services that are available in the clients' own communities.

Does the Continuum of Care's client selection policy include adequate controls to ensure that clients are selected in accordance with legislative intent and with a minimum of delay and expense?

We reviewed the Continuum's client selection process and determined that it has adequate controls to ensure that those children who are severely emotionally disturbed and have exhausted available services are selected to receive Continuum services. However, delays and expense are effects of the process. Also, the Continuum has not promulgated regulations for its eligibility criteria as required by the Administrative Procedures Act (APA).

The Continuum's mandate, stated in §20-7-5640 of the South Carolina Code of Laws, is to serve severely emotionally disturbed children who have exhausted available treatment resources. This section also requires the Continuum of Care to establish criteria for selecting who will receive its services. This has been a two step process. First, the Continuum has established general eligibility criteria. Second, the Continuum has established a procedure for prioritizing the eligible applicants and selecting those with the greatest need of Continuum services.

Eligibility Criteria

According to Continuum policy, applicants must meet five basic eligibility criteria to be considered for a client position. The applicant must:

- Legally reside in South Carolina;
- Be within 6 to 16 years of age at the time of application;
- Have been identified as severely emotionally or behaviorally disturbed by a department of education certified school psychologist, licensed clinical psychologist, or a psychiatrist;
- Have treatment needs that are not being met by existing service delivery systems; and
- Have consent of parent(s), legal guardian, or the agency holding custody, for release of information and receipt of Continuum services.

The Continuum has not been able to serve all applicants who are eligible. As of June 30, 1989, the Continuum had 234 clients. There were an additional 197 eligible applicants for whom no client position was available.

Application Procedures

Applicants are referred to the Continuum of Care by other state agencies, parents/guardians, or other interested parties. Completed applications are returned to the appropriate regional office where they are reviewed by Continuum personnel to determine if the applicant meets the eligibility criteria discussed earlier. Referring parties may request assistance from the regional office in completing the application.

Applicants who meet the five eligibility criteria undergo further screening to determine their degree of need for Continuum services. The Continuum uses a standardized psychosocial evaluation to develop a written profile of the applicant's history and the scope of the applicant's needs. The completed psychosocial evaluation is scored using a standard scale with points awarded for the duration and severity of the applicant's disturbance and the extent to which available services have been exhausted. Once the psychosocial evaluation is scored, the applicant is placed on the waiting list for an available client position.

However, being placed on the waiting list does not guarantee acceptance to the Continuum. All applicants from a region compete for available client positions in that region on the basis of the severity of their need, as indicated by their psychosocial scores. The length of time spent on the waiting list does not establish priority for selection.

The Selection Process

The Continuum establishes the number of clients that it will serve each year based on the annual service development plan (see p. 7). When new client positions become available, or a client leaves the Continuum, a new client is selected from the applicant waiting list. New clients are selected by three-member selection panels. Each region has a selection panel comprised of

volunteers who are recommended by Continuum regional directors and approved by the policy board. The only written criteria for panel members is that they be independent of the Continuum. However, a Continuum official stated that the current selection panelists have a broad range of qualifications and experience in children's services.

Each selection panel considers two more applicants than the total number of available client positions. Those applicants with the highest psychosocial scores are considered by the panel. The selection panelists are given the applicant's history and other written information obtained through the psychosocial evaluation process, but not the actual psychosocial score. This process of choosing without knowledge of the scores tends to eliminate some bias in the psychosocial scoring system. The two applicants who are not selected may be returned to the waiting list or determined to be ineligible for Continuum services.

Applicants who are passed over, or determined to be ineligible, by a selection panel may appeal that decision to the Continuum's state appeals committee. If the appeals committee upholds the selection panel decision, the applicant is referred to the Children's Case Resolution System. According to a Continuum official, the appeals process has been used only once in the history of the Continuum.

Although most clients have been selected as a result of the process described above, clients have also been placed in the Continuum by the courts. According to a Continuum official, 25 clients were court ordered into the Continuum from January 1986 to April 1990.

Policy Changes

In reviewing the consistency of the selection process, we found the process has experienced three major changes since July 1, 1986.

- Membership of the selection panels has been changed. Prior to October 1987, two of the existing four selection panels were staffed by paid professional psychologists, psychiatrists and educators, while the other two selection panels were

staffed by representatives of the other major child-serving state agencies.

- The psychosocial evaluation was implemented in 1987. Prior to this evaluation, the Continuum used a simple ten-point rating system to determine which applicants would have priority for selection.

- Selection panel meetings have been closed to the parties who refer applicants being considered for selection. Until March 1987, referring parties were permitted to appear before the panels and advocate for their applicants. This may have resulted in applicants being selected more on the merits of the referring party's argument than on the applicant's need.

We conclude that changes in the selection process have been generally positive and have strengthened controls to ensure that appropriate applicants are chosen.

Selection Process Effects

In addition to the fact that not all eligible applicants are served, the Continuum's selection process has three major problems:

- The process is usually slow.

- Contact between the Continuum and referring parties is not documented and may be inadequate.

- The psychosocial evaluation is expensive.

As of June 30, 1989, there were 180 applicants on the waiting list, and 17 more eligible applicants who had not received psychosocial evaluations. Those on the waiting list averaged approximately nine months since applying to the Continuum. Forty-seven of the 180 were accepted into the Continuum between July 1, 1989, and December 31, 1989. The average total waiting time for this group of 47 was approximately eleven and one half months. There is no way of accurately predicting when or if an applicant will be selected for a client position. Each new applicant has potentially greater need for Continuum services than all of the other applicants on the waiting list.

We identified communication between the Continuum and the referring parties of applicants as an area where improvements could be made. Because applicants are not selected on a first come first served basis, lengthy delays are unavoidable for some applicants. Continuum policy requires contact every four months between the regional offices and the referring parties of applicants on the waiting list. However, no documentation of these contacts is required, so Continuum management does not have adequate controls to ensure the contacts are actually being made.

Further, this policy does not apply to applicants who are not yet on the waiting list. Applicants may spend months completing the application and psychosocial evaluation process. Fifty-four applicants on the waiting list as of July 1, 1989 had applied for Continuum services more than one year earlier. Among this group, the average time spent in the application and psychosocial evaluation process was approximately six months. According to Continuum officials, each region follows its own policy of contact with referring parties at this stage. Inadequate communication may result in the perception by referring parties that the Continuum is not giving appropriate priority to timely selection.

The psychosocial evaluation and scoring process is expensive. From October 1987, when psychosocial evaluations were officially began, until June 30, 1989, the Continuum performed 265 psychosocial evaluations. Continuum records indicate that each psychosocial evaluation costs from $200 to $225 to administer. Therefore, as of June 30, 1989, psychosocial evaluations had cost, at a minimum, an estimated $53,000. Many of the applicants who received these evaluations may never be selected as Continuum clients. The Continuum is currently studying changes to the selection process which might include other less expensive measurement techniques.

The Administrative Procedures Act (APA)

The Continuum's eligibility criteria and selection procedures have not been promulgated in regulations as required by the APA (§1-23-10 to §1-23-160 of the South Carolina Code of Laws). The APA generally requires that an agency's policies

which have "general public applicability" be promulgated as regulations. The process includes giving public notice in the State Register, allowing participation by interested parties, and approval by the General Assembly. The APA process allows the General Assembly and the public to review the Continuum's policies in implementing the law.

Continuum staff stated that they plan to promulgate regulations for the client eligibility criteria.

Recommendations

1 The Continuum of Care should continue to refine its client selection procedures to reduce the delays and improve economy in the selection process.

2 The Continuum of Care should establish a policy requiring documented recurring contacts with the referring parties of all applicants. These contacts should continue until the applicant is either selected as a Continuum client or is determined to be ineligible.

3 The Continuum of Care should promulgate regulations for its eligibility and selection criteria as required by the Administrative Procedures Act.

What has been the Continuum of Care's average cost per client served, and is this reasonable?

We found the average cost per Continuum client to be approximately $18,319, $20,298, and $23,045 in FY 86-87, FY 87-88, and FY 88-89, respectively (see Table 3.1.), and concluded these costs have not been unreasonable.

Table 3.1: Average Cost Per Continuum of Care Client

Fiscal Year	Total Expenditures	Clients Served	Average Cost Per Client
86-87	$3,462,238	189	$18,319
87-88	4,506,130	222	20,298
88-89	$6,106,928	265	$23,045

Source: Unaudited Department of Mental Health accounting records and Continuum of Care.

The Continuum of Care broadly categorizes its expenditures as administrative, case management, and purchased services. During the three years ending June 30, 1989, the average percent of total expenditures for administration was 11.56%. Case management and purchased service costs averaged 34.45% and 53.99% of the total costs, respectively (see Table 3.2.)

Table 3.2: Allocation of Continuum of Care Costs

Fiscal Year	Administration	Case Management Services	Purchased Services	Total
86-87	$587,499	$1,381,547	$1,493,192	$3,462,238
87-88	482,553	1,653,209	2,370,368	4,506,130
88-89	557,657	1,814,015	3,735,256	6,106,928
Total	**$1,627,709**	**$4,848,771**	**$7,598,816**	**$14,075,296**
Percentage	**11.56**	**34.45**	**53.99**	**100.00**

Source: Audit Council analysis based on the Continuum of Care allocation method.

Administrative cost includes only expenses of the state office. The Continuum of Care received accounting, legal, procurement, and personnel support from the Department of Mental Health (DMH) until July 1, 1989. The cost of this support is not

reflected in Tables 3.1 and 3.2. DMH estimated the cost of Continuum support to be $45,901 ($243/client), $51,295 ($231/client) and $54,146 ($204/client) in FY 86-87, FY 87-88 and FY 88-89 respectively. Under legislation passed in 1989, as of July 1, 1989, the administrative support functions were transferred from DMH to the Health and Human Services Finance Commission.

Case management services are provided by Continuum staff directly to clients. These services include assessment of client needs, service planning and procurement, monitoring of service provision, evaluation of service and client outcomes, and supportive counseling and advocacy. In Table 3.2, case management includes all operating costs of the five regional offices except services purchased for clients. Salaries of case workers and their supervisors, and fixed charges account for most of the case management costs. Also included in case management is a portion of the state office expense attributable to supervision of the regional case management personnel.

Purchased services include educational, treatment, residential services and support costs incurred for the clients. Table 3.3 shows the percent of purchased services costs incurred for each of these categories in FY 87-88 and FY 88-89. This information was unavailable for FY 86-87.

Table 3.3: Purchased Service Cost Summary By Type

Service	FY 87-88	Percent	FY 88-89	Percent
Residential	$1,488,495	63	$2,265,424	61
Treatment	729,586	31	1,318,918	35
Education	121,303	5	123,735	3
Support	30,984	1	27,179	1
Total	**$2,370,368**	**100**	**$3,735,256**	**100**

Source: The Continuum of Care-unaudited.

The Continuum purchases services through program and individual contracts (see p. 7).

Comparative Information

We attempted to identify programs in other states which are similar enough to the Continuum for comparison of the average cost per client served. North Carolina's Willie M. program is the most directly comparable program to the Continuum that we identified. This program serves children who are severely emotionally disturbed *and* assaultive. The Willie M. program is administered through 41 area mental health centers. The Office of Willie M. Programs reimburses area programs for the cost of services provided to certified eligible children. According to information supplied by Willie M., the average cost per Willie M. client served was $20,540, $22,855, and $23,499 in FY 86-87, FY 87-88, and FY 88-89, respectively. Table 3.4 compares the Willie M. average costs per client to those of the Continuum, including the estimated DMH costs.

Table 3.4: Comparison of Average Cost Per Client Served: North Carolina Willie M. Program and the Continuum of Care

Fiscal Year	Willie M. Program Costs	Clients Served	Willie M. Average	Continuum Average
86-87	$27,010,614	1,315	$20,540	$18,562
87-88	28,385,854	1,242	22,855	20,529
88-89	$29,633,047	1,261	$23,499	$23,249

Source: The North Carolina Office of Willie M. Programs, the South Carolina Department of Mental Health, and the South Carolina Continuum of Care.

Based on this comparison, the average spent per client by the Continuum of Care does not appear unreasonable. Also, because the Willie M. program operates on a fixed rate reimbursement system, its actual costs may be higher than shown. According to an official of the Willie M. program, many of the area mental health centers claim that the reimbursement rates are too low.

We also obtained cost information from other South Carolina state agencies serving emotionally disturbed children. Differences in client population, services offered, and data available would not allow us to make meaningful comparisons.

The Continuum of Care has a dual mission of service development and case management. Because the Continuum is still a new organization, many of its costs are related to developing services. For example, the Continuum paid $500,000 for start-up costs of a crisis stabilization program in the midlands region during FY 88-89, and will pay another $190,000 for this program in FY 89-90. The Continuum expects the funds paid in start-up costs to be recovered over a period of years through a reduced unit rate for services provided for Continuum clients. As the array of Continuum services becomes complete, the average cost per client served should decrease.

The Continuum began receiving Medicaid reimbursement for case management services in FY 89-90. The Continuum estimates $300,000 of reimbursement will be received in FY 89-90, and this amount is expected to increase in the future. These reimbursements will reduce the state's portion. However, intensive case management requires a high ratio of staff to clients, and this will remain an expensive part of the Continuum's operation.

How does the Continuum of Care measure client progress and are management controls adequate to ensure that clients receive effective service?

Client Outcome Surveys

The Continuum of Care has conducted surveys of client progress annually since 1987. Case managers complete the surveys for each child by indicating those areas that were considered problematic when the child became a client and whether the child has made progress since receiving Continuum services. The measures, developed by Continuum staff, with the 1989 survey results are the following:

Since entry has the client:	"YES" (%)
Moved to a less restrictive educational placement?*	46
Shown an increase in academic achievement?*	65
Demonstrated improved behavior in the school setting?*	64
Attended school more regularly?*	70
Received fewer suspensions or expulsions?*	64
Had less incidence of running away?	76
Moved to a less restrictive out-of-home placement?	56
Remained in foster or group care for longer periods of time without disruption?	70
Required less frequent or less long-term hospitalization?*	78
Required less medication?*	64
Been involved in fewer or less severe delinquent behaviors?*	69
Shown progress in family relationships?	68
Shown progress in peer relationships?	72
Been more accepting of treatment services?	80
Moved to a less intense "Client Status"?*	66

For indicators marked with an asterisk (*), the case coordinator is to use responses from outside professionals, such as education or medical personnel. The survey is informal and documentation is not required for the responses. Results, as shown above, have shown a favorable trend which improves with the duration of services.

A review of the literature does not yield answers about how the Continuum should measure outcomes. The North Carolina Willie M. program has not done outcome surveys. Most formal outcome studies have evaluated a particular treatment (such as hospitalization) rather than a system of services, such as that provided by the Continuum. However, apart from research

value, client outcome evaluation can be a useful tool to improve program management decisions and program effectiveness.

Recommendation

4 The Continuum of Care should consider modification of its client outcome surveys to require documentation of professional response to relevant indicators.

Controls for Effective Services

The staff of the Continuum of Care have demonstrated an ongoing concern with evaluation of the services received by clients. The agency has reviewed performance of case management services, which are furnished by the Continuum's case services coordinators, and the services furnished by vendors with whom the Continuum has program contracts. Evaluation methods have continued to evolve, as improvements have been implemented. However, the Continuum's controls are less adequate in the area of contracts for individual client services.

Case Management Services

The Continuum has defined service standards to assure that case services coordinators maintain regular contact with their clients and adhere to agency policy for monitoring and documenting client progress. Quarterly file reviews are completed by state office staff to ensure that service standards are met and to monitor the quality of case record documentation. The regional offices also review files and regularly report on the status of their cases.

We reviewed documentation for these activities for FY 87-88 and FY 88-89, and found evidence that sound management controls exist to ensure the effectiveness of the Continuum's case management. Further improvements to the evaluation of case management services to provide greater stress on qualitative issues and on the documentation required for Medicaid recoupment are underway in early 1990.

Program Contracts

For FY 89-90, the Continuum has 21 program contracts with a budget of $3.8 million. Program contracts provide a service, such as a high management group home, for a number of Continuum clients. The Continuum annually conducts systematic comprehensive evaluations of the programs for which it contracts. The annual program reviews are conducted by a team of Continuum staff and include evaluations of program administration and operations, facilities, staff interviews, records audits, and consumer satisfaction surveys. The results of the reviews are presented to the policy board for contract renewal decisions. Also, as a part of the program evaluation process, each program is required to develop a system for internally measuring program effectiveness and to report quarterly results to the Continuum.

We reviewed documentation for the program contract review process for FY 87-88 and FY 88-89, and concluded that it provides sound management controls likely to ensure the quality of these services. Improvements used in the 1989 reviews will help clarify follow-up procedures. We did note that the Continuum's program contract management manual calls for quarterly program monitoring in addition to the annual program reviews, and this monitoring has been completed only one time for four programs. This omission, however, has not materially affected the adequacy of the controls, but indicates a need for the Continuum to include availability of staff and resources in the process of planning for program evaluation.

Individual Contracts

The Continuum of Care does not have adequate management controls to ensure quality of the providers who have contracts to provide service to individual Continuum clients.

The Continuum initiated 774 individual contracts in FY 88-89 that totalled approximately $1.8 million. Individual contracts are arranged for a wide variety of services. These include services such as positive role model, for which providers do not need specific professional qualifications; and services such as therapy, for which specific professional qualifications should be required.

The Continuum has no written qualifications for providers of the individual services it purchases for clients and does not require documentation of qualifications. Documentation of licensure is not required for residential homes and facilities. Also, evaluation of the provider's service by the client's case services coordinator appears only in the client's case file. No evaluation that can be accessed by the provider's name is maintained.

Services which require special skills and training should be performed by those licensed or qualified to provide them. Documentation of credentials is necessary to ensure the requirements have been met. Formal evaluation of providers could provide useful information for Continuum staff who need to purchase services for clients at different times or locations. Maintaining information about providers apart from individual clients' cases could also save time, because information and documentation of the providers' qualifications could be acquired and reused as needed.

Also, if the qualifications for providing a particular service are specified, there is more guarantee that the compensation rate for that service is consistent. Many of the Continuum's contracts are sole source, because the therapeutic match between the client and the provider must be satisfactory for the contract to be successful.

Continuum staff stated that individual providers for some services must have particular qualifications, though they are not written. Continuum clients can stay overnight only in facilities that are licensed by the Department of Social Services. Also, the Continuum started requiring criminal reference checks in the fall of 1989 for individual contract providers.

Recommendations

5 Where relevant, the Continuum of Care should establish written minimum qualifications and require documentation of licensure for service providers.

6 The Continuum of Care should maintain information about and evaluations of service providers in a format which can be accessed by provider name.

How many Continuum clients have been placed in out-of-state treatment programs, and why?

We confirmed that 30 Continuum of Care clients received treatment, from July 1, 1986 to June 30, 1989, in residential placements located outside of South Carolina. Twenty-three of these remained out-of-state on June 30, 1989. These placements occurred although a basic Continuum tenet states that treatment should be administered in the client's own community whenever possible. According to §20-7-5610 of the South Carolina Code of Laws, effective May 1989, the Continuum is to ensure that the needs of severely emotionally disturbed children are met "appropriately to the extent possible within this state." A shortage of long-term residential nonhospital facilities, and the lack of an adequate sex-offender treatment program in South Carolina have been cited as the reasons for many of these placements.

According to our survey of Continuum case service coordinators, 22 (73%) of the 30 children in out-of-state placements needed a long-term residential nonhospital treatment program. This type of placement differs from group and foster homes in that a full array of services is normally offered within the facility. This arrangement is necessary because children in need of this service are often too aggressive or disturbed to attend public school or vocational training. Twenty-six of the 30 children were reported as exhibiting some assaultive behavior, including 13 who were described as frequently assaultive. Seventeen of the 30 children were described as frequent runaways. Most of these children had experienced multiple out-of-home placements prior to placement out-of-state. According to the survey responses, they averaged 9 out-of-home placements from July 1986 until they were placed out-of-state. We found the average age at the time of out-of-state placement was 15.

According to a 1988 Continuum survey, there was only one provider of long-term residential nonhospital treatment in South Carolina, and that provider had limited service availability. The Continuum's current service development plan does not include plans to develop any new long-term residential nonhospital treatment programs. Instead, the Continuum expects a combination of services, including high management group homes, therapeutic foster homes and secure crisis stabilization units to fill this need. This combination of services can be

community based, and should be more economical than a nonhospital residential facility.

Twenty-one of the 30 out-of-state children exhibited some inappropriate sexual behavior. Continuum officials state that there is no program in South Carolina designed to meet the needs of sex offenders and children who act out sexually. The Continuum's 1989 service development plan includes a sex-offender treatment program scheduled to be implemented when the agency's budget reaches the $12 million level. This program is not considered a high priority due to the small percent of the total client population in need of this service.

The Continuum of Care has not been solely responsible for placing its clients out-of-state. Six of the children were placed out-of-state prior to becoming Continuum clients. Twenty-six of these placements involved the Children's Case Resolution System (CCRS). The CCRS, a division of the Governor's office, reviews cases where children may be receiving inadequate services, and arbitrates cases when multiple agencies cannot agree on the services to be provided. Under §20-2-5230 of the South Carolina Code of Laws, CCRS decisions are generally binding on the agencies involved.

All placement decisions involving Continuum clients are made by the total service planning (TSP) team assigned to each client. These teams are comprised of representatives from the other children's service state agencies, the family or guardians, and in some cases, a representative of the CCRS. A Continuum case service coordinator chairs the treatment team, but has no more decision authority than any other team member.

The agencies participating in treatment decisions often share the cost of the placements. Beginning October 30, 1989, the Continuum implemented a policy of paying a higher percentage of the cost of in-state placements than of out-of-state placements. This policy is intended as an incentive to the other participating agencies to support in-state placements whenever possible. A proposed Continuum directive also requires an extensive management staff review of all cases where out-of-state placement is being considered by a TSP team. The Continuum's executive director must give final approval in all

instances where the Continuum recommends placing a client out-of-state.

As of January 31, 1990, we found that 15 of the 30 (50%) Continuum clients in out-of-state placements during the 3 years ending June 30, 1989, had returned to South Carolina. The average length of out-of-state placement for these clients was approximately 17 months.

The Continuum has specific minimum service standards for its clients in out-of-state placements. Continuum case service personnel must make telephone contact with the client once every 20 working days and visit the client once every 6 months. Also, the client's TSP is reviewed and updated at six-month intervals.

A 1988 report by the National Mental Health Association (NMHA) concluded that the most appropriate mode of treatment for children with emotional problems is often a community-based service. However, the practice of placing emotionally disturbed children out-of-state is widespread. The NMHA report showed that nationally in 1986-87, 4,098 children had been placed out-of-state by state agencies. Thirty-four of these children were reported by South Carolina. The average number of children placed out-of-state by the 8 southeastern states was 41. Georgia reported 124 children while North Carolina and Alabama reported none.

In conclusion, out-of-state placements are not in accordance with the Continuum's policy favoring community based treatment. However, the decisions to place Continuum clients out-of-state were not made solely by the Continuum, and, in some cases, they were made prior to Continuum involvement with the child. The Continuum has documented plans designed to reduce the need for out-of-state placements. Also, the agency is trying to prevent new out-of-state placements through the use of higher cost sharing for in-state placements, and a more thorough review of out-of-state placement decisions.

Issues for Further Study

Management Information About Services

In the course of our review of services offered by the Continuum of Care, an issue for further study was noted. The Continuum's automated information systems do not produce adequate management information about services received by Continuum clients and costs related to those services. While this issue was not judged to be central to the audit's objectives, evidence indicates that the Continuum needs to improve its information system controls and capabilities.

The Continuum cannot produce consistent and accurate information about the number of clients receiving a particular service, the number of units of the service received, what source is paying for the services, and the cost of those services. The Continuum has an automated accounting system and an automated client information system, but they are not integrated. Controls to assure consistency and accuracy in the service data entered in the client information system are inadequate. The North Carolina Willie M. program has a comprehensive data base that includes client and cost information for each service offered by the program. Such information is needed to aid in evaluation and management decision-making.

Source of Funding

As we developed background information and reviewed the Continuum's services and selection policies, we found that the source of the agency's funding, which has not yet reached a level to allow it to serve all eligible clients or to develop services throughout the state, has been an unresolved issue (see pp. 7, 13). Whether the Continuum should continue to be funded with Education Improvement Act (EIA) funds or some other source of appropriation has not been determined.

According to the original plan for EIA funds, the Continuum was to receive EIA funds to reach $10 million phased in over a 5-year period beginning in 1985. However, EIA funding allocated to the Continuum has not reached this level; $4 million in EIA funds was received in FY 88-89.

The use of EIA funds was thought to be appropriate because the Continuum of Care provides related services necessary to help emotionally handicapped children benefit from educational programs. According to the Education for All Handicapped Children Act (20 US Code §1401 *et seq.*), these services must be provided to all handicapped children as needed. However, the appropriation of EIA funds for the Continuum has also been questioned. The 1988 report of the EIA Five-Year Program Plan Task Force recommended deleting the Continuum from the EIA and funding it through mental health. The report states ". . . education is just one facet of the broad care system required by severely emotionally handicapped students."

While not central to audit objectives, this unresolved issue has an effect on the Continuum's ability to fulfill its statutory mandate to serve its target population.

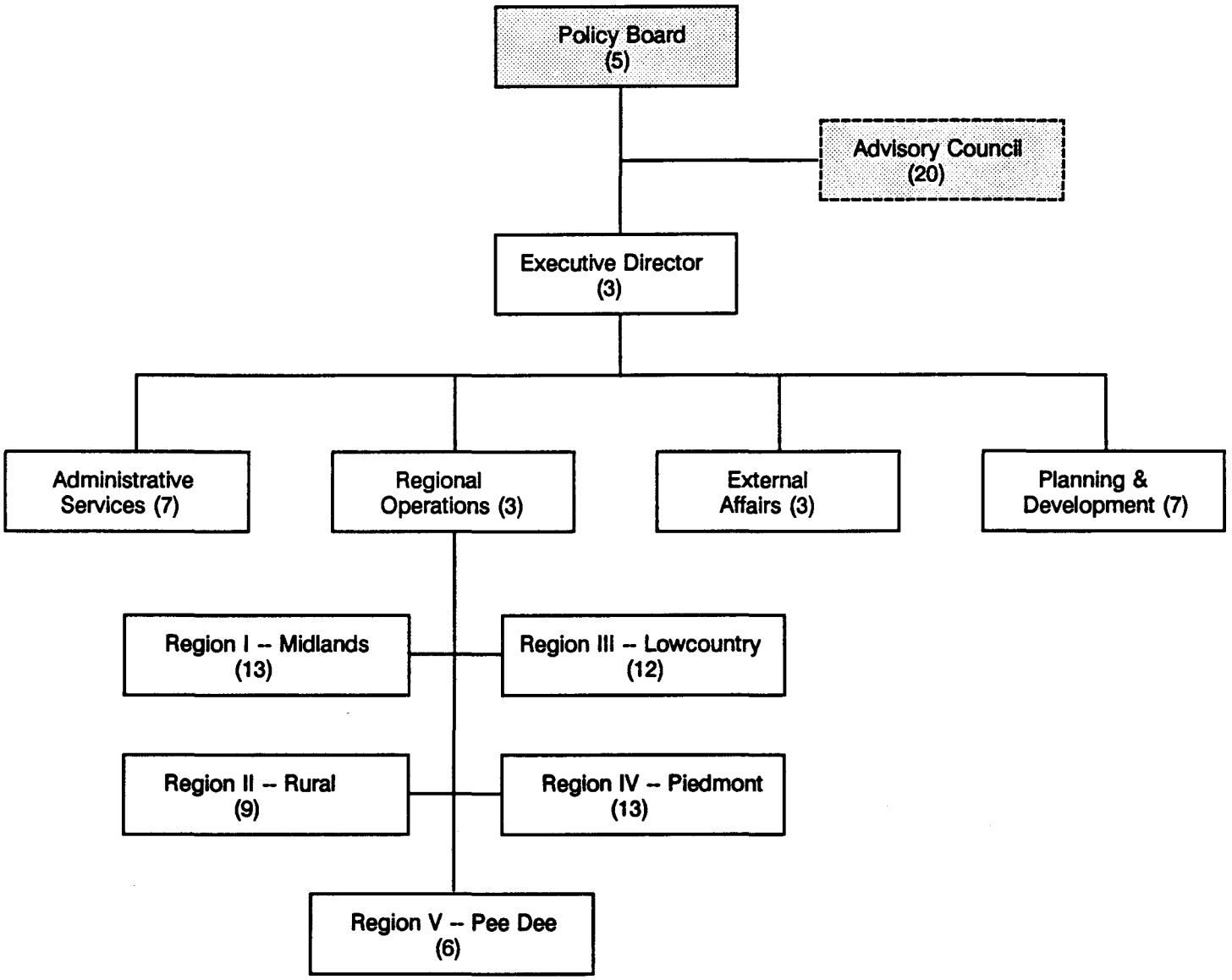
Appendices

Purchased Services by Region[a]

Year	FY 86-87						FY 87-88						FY 88-89						3-YEAR TOTAL
Region	I	II	III	IV	V	TOTAL	I	II	III	IV	V	TOTAL	I	II	III	IV	V	TOTAL	
Number of Clients	62	31	41	45	3	182	66	32	40	52	15	205	70	40	42	61	21	234	
Education Services																			
Regular Public Schools														1				1	1
Itinerate Educational Services																			
Resource Room							1					1	2					2	3
Self-Contained																			
Psycho-educational Services	23					23	17	1			1	19	16					16	58
Homebound Instruction																			
Tutoring	7	23		4	1	35	4	15		10	3	32	7	15	1	12	11	46	113
Treatment Services																			
Early Identification and Treatment																			
Psychological Evaluation	5					5	17	3	2	12	20	54	3			3		6	65
Medical/Psychiatric Evaluation		2				2		1		1	1	3	1					1	6
Counseling							3	1		2	1	7	2					2	9
Therapy	3	17		6		26	6	22	5	4	2	39	36	17	14	7	3	77	142
In-Home Family Intervention			2	1		3	2	2	3	2	3	12	3	1		6	17	27	42
Day Treatment			16			16			11			11			14			14	41
Community Crisis Stabilization	2		6			8			1		2	3	3		3			6	17
In-patient Crisis Stabilization			2			2		1				1	4	2				6	9
Short-term Non-Hosp. Eval. & Treatment																			
Short-term Psychiatric Hospital										1		1	1			4		5	6
Long-term Psychiatric Hospital													2					2	2
Activity Therapy	58	27	83	47	2	217	54	30	29	23	10	146	39	39	28	27	18	151	514
Positive Role Model		18		2	1	21	6	44	5	14	21	90	18	31	25	25	40	139	250
Behavior Management							11	13		12	6	42	34	17	2	10	4	67	109
Independent Living Skills							7		1			8	6		1			7	15
Vocational Services	3	1				4							2			4		6	10
Residential Services																			
Supervised Independent Living									2			2			8		2	10	12
Respite	7			3		10	15	4		8		27	17		4	11		32	69
Foster Care															1			1	1
Low/Mod. Mgmt. Therapeutic Foster Care		1				1	3					3					1	1	5
High Mgmt. Therapeutic Foster Care	14					14	13	7				20	8	8		1		17	51
Low/Mod. Mgmt. Therapeutic Grp. Home Care	2		7	26		35	3		3		1	7	6	5	4	1	4	20	62
High Mgmt. Therapeutic Grp. Home Care	13		2			15	20	1	4	33	2	60	23			18		41	116
Wilderness Camp	7		1	2		10	9		2	3		14	5		1	4	4	14	38
Long-Term Residential Treatment	3	1	7	1		12	2	2	23	3	2	32	24	7	28	30	6	95	139
Support Services																			
Transportation		15				15	1	38	1	2	5	47	6	34	8	5	7	60	122
Clothing																			
Medical																			
Legal																			
Other																			

[a]Numbers reflect number of Continuum-funded contracts for individual services, number of participants in Continuum programs. Does not include services paid for by other agencies or by the Continuum by means other than a contract.
Source: Continuum of Care service development plans, FY 86-87 through FY 88-89.

Continuum of Care Organization Chart



Total FTEs = 78 (2 unallocated)
March 1990

Agency Comments

South Carolina
Continuum of Care for Emotionally Disturbed Children
1340 Pickens Street / Columbia, South Carolina 29201 / (803) 253-6272

May 10, 1990

Mr. George L. Schroeder, Director
Legislative Audit Council
400 Gervais Street
Columbia, South Carolina 29201

Dear Mr. Schroeder:

On behalf of the Board and staff of this agency, I wish to express to you sincere appreciation for the recent report of the Legislative Audit Council's review of the Continuum of Care. We were pleased to have this external review of the Continuum's operations and success in meeting legislative intent. We commend the staff of the Council who were involved in this audit for their thoroughness and professionalism.

The report's conclusions are very affirming. The Continuum's case management services are being provided to clients statewide and implementation of the strategic plan for service development has been underway for the past four years. The recommendations encourage us to continue these efforts to ensure that the needs of our State's severely emotionally disturbed children and their families are met with integrity and accountability.

Sincerely,

Paula B. Finley

Paula B. Finley
Executive Director

PBF/Psw

Legislative Audit Council

400 Gervais Street
Columbia, SC 29201
(803)253-7612